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Editor-in-Chief
MARIE A. HINRICHS, M.D., Ph.D.
Riverside, Ill.

Assistant Editors
DONALD A. DUKELOW, M.D.
Chicago, Ill.
GERTRUDE E. CROMWELL, R.N.
Denver, Colo.
EDWARD B. JOHNS, Ed.D.
Los Angeles, Calif.

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THE JOURNAL OF SCHOOL HEALTH

Devoted to the interests and advancement of school health service and instruction. Your participation by membership is solicited.

VOL. XXVIII JUNE, 1958 No. 6

FAMILY LIFE EDUCATION IN THE SCHOOL HEALTH PROGRAM*

ANNE R. FALTHER, R.N.

Director, Family Health Association, Cleveland, Ohio

Dr. C. E. Turner, in his book "School Health and Health Education," defines Family Life Education as "the sum of experiences which favorably influence *habits, attitudes,* and *knowledge* relating to the individual, community, and familial health."

If this definition is true, then we can safely assume that there is no school that does not have some kind of family life education, since all education endeavors to favorably influence habits, attitudes, and knowledge. However, we know that there can be considerable negative learning in our daily school life, so we must first evaluate the quality of our teaching, and the preparation and attitudes of those who teach, if we plan to think in terms of this overall program of Family Life Education.

Before we say there is no course in our school, let's look over the total school curriculum. Any school program of Family Life Education must be adapted to the needs of the (1) community, (2) parents, (3) students and school; however, when you begin to look over your curriculum, you may find that every subject can make a contribution, either directly or indirectly, to this broad program. This is in itself evidence of the importance of curricular integration, which certainly should be fostered all along the way.

How would you approach this over all exploration study? Appoint a committee of teachers, school administrators, health counselors, etc. They should begin as follows:

1. Set up some goals.
2. Look over the State syllabus, if one is available. Study it. Build on it. Call in some key people (community resources).
3. Check curriculum of each discipline in the school—find out what they are teaching in Family Life.
4. Review findings—shift load a little, if possible—try to eliminate some of the duplications and suggest ways of strengthening the existing curriculum.
5. Get faculty as a whole interested in suggested outline. This is really the most crucial spot.

Make use of all resources within your own teaching staff before setting up an entirely new course. If you need help, ask for it.

*Presented before the Health Instruction Section, American School Health Association, 31st Annual Meeting, Cleveland, O., Nov. 13, 1957.

Today we are considering Family Life Education in the school Health program — and rightly so, since strong families are built by physically, emotionally, socially, and spiritually healthy parents. To improve our educational methods, we must think in terms of both the direct and indirect approach.

Family Life Education has not been a part of an organized curriculum for too many years and there are still many schools where there is no structured approach to this type of learning. The progress has been slow for many reasons, and some of the most common reasons are (1) our reluctance to encroach on territory which the teacher feels belongs in the home, or (2) fear that parents will object, or (3) fear that parents will turn the job over completely to the school. My personal belief is that the school cannot take over the job and certainly does not want to do so.

If we are to believe all the research that has been done by sociologists and psychologists, then we know that the most important and basic Family Life teaching occurs in the first five years and the child comes to school with all of these attitudes and ideas. The school's main job is to strengthen the strong points that the child brings from home, and modify or change the weaker ones.

In the early school days, the approach would certainly be indirect. By the time the child is in the 4th grade and his relationships with others is broadening, it may be well for the teacher to approach this whole subject of relationships on a more organized planned basis. It certainly need not be labeled Family Life Education, but could be set up as a multiple procedure of classroom sessions by the teacher and outside sessions by a visiting teacher, or a weekly social relations training session of the classroom group as a whole, conducted by the classroom teacher. This and several other methods have been developed by the Research Center for Group Dynamics at the University of Michigan.

We believe that children who have been helped to develop personal strengths and personal insights will be potentially better prepared for effective family living, than will those who have not had these advantages.

In the 10th to 12th year of life, children begin to show definite marks of physical maturation. The teacher should build on the basic needs and interests of this age group by developing an entire unit in the health and social studies area on maturation. We have a program such as this in many of our greater Cleveland schools, emphasizing emotional, social, and physical growth as it

relates to personality. The teacher should make use of the content of this course many times during the week as it relates to daily living. This, too, is a part of Family Life Education if we accept the definition of Dr. Turner. In the elementary grades the teacher's main emphasis should not be on content, but rather on attitude towards one's self and others.

In Junior High School, social relationships and social skills are very much the concern of teen agers, as well as parent-child relationships. Here, too, the school as an "objective onlooker" can reach the student more effectually and help to strengthen the family ties much more adequately than almost any other source because the student is looking for help but does not want a finger pointed at him personally. "Thinking out loud," with his peers, is most helpful, especially if this is done under the guidance of a competent teacher.

Although the teacher in Junior High School can not be as permissive in content structure as in the senior high classes, there should be shared planning between teacher and pupil — as

1. What are the things that the students are interested in?
2. What do they think is important?

The teacher's job is to guide, suggest and direct. She may need at times to stimulate or create a feeling of need.

Some general areas in which many pupils voice their need for help include:

1. Understanding themselves.
2. Understanding their friends.
3. Relationships to their home and family—especially to brothers and sisters.

In these areas we are many times doing a job of helping these young people to begin to know themselves.

Where do you teach this? I'd say it could and should be woven throughout the entire Junior High years but one person, and frequently the Health coordinator, should be responsible for holding the content together.

In the Senior High much of Family Life Education is re-education and becomes a building process. There is now definite need for more formal structured planning since many potential family members will not complete High School. In the 10th grade some direct guidance should be given. In one of our local High Schools a course such as this is taught to boys and girls together. It is called "Education For Life" and really is basic preparation for marriage and family living. Here I would emphasize the impor-

tance of content but even more so the personality and character of the teacher.

Marriage and Family courses are taught in many 12th grades — and certainly are important. No course outline can really be completely set up since the students by now should have considerable choice as to what they wish to include. This course definitely could be taught by the Health, Biology, Social Studies or Home Economics teachers, etc., each participating in a larger program. Perhaps others too may be included, since family living is a part of *all of life* why not try to help the students see it as an integrated part?

As in all classes in this area, the most important aspect of all is the philosophy of the school administrators. If there is a negative attitude at the top it is felt all the way down to the student body. If the administration does not put value in this course neither will many students.

To do a more effective job today schools must recognize that they need to supplement the home, that the best tools of the day should be used to teach a class in Family Life Education just as in any other course, but most of all that the teacher who is assigned to teach this subject should be better qualified, have better preparation in Human Relations, and have an understanding heart as well as the respect of the students.

Last, but certainly not least, in order to make a Family Life program effective, the parents should be included in the over-all planning so that the home and the school can work together more effectively.

In any area of Family Life teaching we must remember that a child brings his background with him and that he is not a vessel into which we pour information but rather that our individual differences makes our responses different. Therefore the teacher should develop patience because the transfer of knowledge into behavior is very difficult.

* * * * *

MEETING

THE AMERICAN DIETETIC ASSOCIATION—(41st ANNUAL)

Philadelphia, Pa. — October 21 - 24, 1958

Sessions and exhibits—Trade and Convention Center. Headquarters hotels—Benjamin Franklin and Bellevue Stratford.—Purpose: To bring to the membership the latest developments in the sciences of nutrition, diet therapy, food technology, education, and food administration.

VITALIZING THE HIGH SCHOOL HEALTH COURSE

FRANCES HOTTENSTEIN, M.A.
Health Teacher, North High School, Akron, O.

Health education has come into its own as an accredited high school course of study. Whether its contribution toward better health in the community will stand the "test of time" depends for the most part upon how well the teaching "takes" with the pupils in the classroom. To be included in the secondary school curriculum the health course has had to replace another one or more courses or else it has been added to the academic load of the pupils, so it would seem that we must expect this area of education to meet well the health needs and interests of boys and girls in the middle teen years. It is paradoxical that when youngsters are experiencing special problems of development as well as general health problems, they are at the same time apt to be having less care and guidance in health matters from their parents. Whether parents are inadequate to help their children wrestle with development and social matters which are greater than prevailed a generation ago, or whether, as parents say—"the school can tell things so much better than we can," it is certain that we school teachers have a big job to do in health education. Since it is true that young people today are given tremendous freedom to live their lives and direct their own futures, we turn to the high school health course as an area of study wherein each child may learn the facts of health which he may incorporate into his own pattern for living the successful and satisfying life we hope he may find.

In our sphere of education there is a golden opportunity to draw together the bits of health knowledge a child has garnered over the years and that which he is acquiring daily from friends, family, television, radio and press and to help him understand his health background and to correct his misconceptions about health.

He must be helped to appreciate good standards of health and to recognize deviations in himself and those for whom he may be responsible. Certain health problems of the future which he shall need to face later must be anticipated for him and some learning in advance be promoted. How to reach the high school pupil and inoculate him successfully with facts, right attitudes and good health practices is *our* problem. We dare not develop a neuroticism in youth nor a fear to face life's possibilities by dwelling upon ill health and yet the health course cannot fail to present the effects

*Presented at the Health Education Section of American School Health Association, 31st Annual Meeting, Cleveland, O., November 13, 1957.

of disease and the need to prevent or attempt to cure such conditions. The health course, then, must be dynamic, interesting, factual and functional in the lives of young people—it must have vitality of content and purpose.

The health education course of the Akron Public Schools is a two semester course and is required in the eleventh year. The segregated classes meet daily, with women teachers for the girls and men for the boys. The broad scope of this course covers six units of study.

Units of Study:

Unit I — Physical Health
Unit II — Social Adjustment and Development
Unit III — Preparation for Family Living
Unit IV — Care of Sick and Injured
Unit V — First Aid
Unit VI — General Safety and Driver Education

When I accepted the invitation to take part in this symposium and to discuss ways of vitalizing the high school health course, I accepted also the challenge to reevaluate my own teaching in terms of its vitality — which approaches to the subject at hand and what tricks of the trade seem to have made real impact upon the fifteen, sixteen and seventeen year old girls whom I am privileged to teach at North High School. You may be interested in a few methods and experiences which I have had with my classes.

One of the first necessities for vitalizing the health course is the establishment of good rapport between teacher and pupils and among the class members themselves in an atmosphere of controlled permissiveness which allows for personal experiences to be shared. We know that doing in relation to learning is the best way to fix a new concept. The health course is a wonderful medium for utilizing group activity and individual participation in learning experiences, and pupils frequently express their appreciation of these opportunities. Aside from the actual practicing of techniques of bed-making and care of the sick or injured person in the unit of study devoted to this special phase of health education, perhaps the screening tests which we do within the classroom as part of the unit on personal health rate highest with the pupils as they evaluate their gains from health education. Two such tests are done by the pupils themselves with the objective made clear beforehand that these experiences are planned to help them discover for themselves where they stand in relation to the norms of vision, and weight and to promote an understanding

of health factors involved in deviations from the normal ranges. Reduced visual acuity, for instance, is too often accepted by a pupil without much concern until he discovers for himself which lines on the eye chart he cannot read while his classmates are doing better. Abstract study of the eye structure and its power of accommodation may be of scientific interest to a few pupils but if we can provide each pupil with an opportunity to test his own vision, more than one of them will ask the questions that motivate the lesson on eye strain with the various effects upon general health and comfort and upon student efficiency. To teach these health concepts requires more than mere verbalizing about eye structure and function, so we turn to our eye model, to charts, to finger manipulation to represent tense lens muscles, (yes — even to the dissection of a hog's eye brought by a pupil from her father's meat market) to help the student really appreciate the delicacy of his visual mechanism and the need for reasonable care and protection of these organs. Most of our young people seek correction for their visual errors quite promptly and seem pleased with having done something about their own problem. This response, of course, is very objective and the new glasses stimulate an admission of improved vision. The teacher has only their word for the fact that some pupils do make changes in lighting arrangements and remove eye hazards from various spots in their environment and others may follow suit as we share enthusiasm.

No amount of talking about body weight and the desirable norms is as meaningful to the young student as the actual weighing and measuring experiences in class. With their own figures so obviously illustrating deviation from the standard ranges in weight and with the figures as read on scale and rod to compare with the chart posted in the classroom — girls, especially, become eager to make changes in food habits and other patterns of living related to metabolism. A study of the health textbooks helps them to understand the safety zones in overweight and underweight conditions. Suggested foods and ways to make the proper foods more attractive to the girl who would rather continue to eat the foods she likes even to her disadvantage becomes the topic for class discussions, teacher and pupils sharing alike in contribution. A set of cards (given to the school by our local Dairy Council) with comparative food values in the various desserts chosen with meals and as snacks can be most successfully used at this point to settle

the calorie argument and to indicate the limited food values in much of the diet of youth.

Always, it seems, the *Battle for Breakfast* must be fought. Breakfast seems to have become the forgotten meal in American homes and this pattern of no food served in the morning catches our school children on the short end. In our high school we do not have the mid-morning food break as industry and business have come to provide so we either eat well before school or pay the price in reduced coefficient of learning as the morning wears on. Oddly enough the very individuals who suffer the distress can suggest the most unusual and often ridiculous reasons for not eating breakfast. A cleverly written article in the local newspaper often provides a fine talking point or new approach to the problem of weight control and the need for breakfast. Here is information from the written page that somehow has more appeal to the lay public than that from the textbook no matter how beautifully printed or illustrated.

Sometimes we can point up some obvious signs of the no breakfast habit with new words or catch phrases, such as—"There is evidence of Hypoglycemia in the class this morning," or "Your hypoglycemia is showing." Last year two close friends in health class decided to find out for themselves about the advantages of eating a good breakfast so we set up a problem and they carried out the experiment. They were both good students in Typing class which met the fourth period in the school day — (often 10:45 to 11:30 o'clock) and this was followed by their health class up to 12:15. For a week these girls kept account of the number of words typed per minute and the number of errors made in their daily work, and during this time they continued to have the similarly adequate breakfast each was accustomed to eat. During the following week their breakfast was omitted and again the daily speed and number of errors in their typing was tabulated. Had not the integrity of these girls and their desire to find out for sure been beyond question, the dramatic variation in their typing would have seemed incredible. Their teacher in that subject thought they showed variance from an A grade to a C level. Besides their inefficiency, the girls were uncomfortably hungry and each developed a headache after the third day. Their final report to the health classes was in the form of a large chart labeled "Breakfast Does Make a Difference" and this chart has served as a motivating factor for their classmates and for the girls of this year too. Inci-

dentally, this experiment was submitted to the Science Fair and was awarded a ribbon. Of course, this project was entirely too limited in every detail to be considered scientifically reliable but since it was done by their own friends whom they appreciate, the girls accepted its validity and some were stimulated to eat breakfast—in hope of improving their grades.

To carry the unit of study on Vigor a bit further, we used an old navy film demonstrating various exercises "to do this and that" for the Figure and the class profited from the clever comments which made the exercises worth trying. We did them in class on several days and mentioned them frequently. Many of the girls are maintaining a regular program of the same exercises to keep them like the girls in the picture — "Shipshape and Ready for Duty." In their written summary of this unit of study, the girls squarely faced their own problem as they had discovered it to be through the screening test, and then they set up a program of changed food patterns and exercises which they felt they could follow. Many of the girls continue to come in to the health room regularly to be weighed. Several went to their family physicians for guidance since they were found to be outside the safety zones in weight-height relationship. Classmate and teacher appreciation of their improvement helps them to continue the struggle. That's part of our job, too.

I should like to describe for you another planned experience which has just recently been concluded with success as evaluated by the pupils and some of their parents who were interviewed. This project involved another screening test but the overall planning was aimed toward "killing several birds with one stone." Delaying this particular activity until late in the unit on personal health makes the inclusion of a urinalysis as a class experience more easily introduced. To start with, we show an excellent film borrowed from the Ohio State Health Department Film Service from the story about a pretty young woman whose diabetic condition is discovered following an injury. The class members learn about routine laboratory testing, and sense the security provided by guidance from the family physician, in time of need. They recognize the destructive effects of "loose medical talk by those who don't know what they are talking about" (to quote the doctor in the film). The problems of the diabetic are explained and assurance is given that the controlled diabetic can live quite normally. This has psychological value for the adolescent who hears about

this disease in his family. The film suggests the laboratory testing of the urine so it is easy now to interest the class in seeing a demonstration of the glucose test. With the use of commercially available tablets, this demonstration with normal and prepared specimens can be done with no fuss or stress and has a strange fascination for the pupils.

The explanation of sugar utilization in the body, its dependence upon insulin production by the pancreas and the spill of excess glucose through the kidney can be made meaningful when an interest has been aroused. Reference now to the magnitude of the public health problem of diabetes and to the value of mass testing as well as routine urinalysis as part of a good physical examination is laying the ground work for introducing the next big class experience to come within a few days. Following the demonstration of the glucose and also the albumin tests, the question is asked, "Would any of you like to run this test for yourselves tomorrow?" In five years of this screening there have always been the several eager pupils whose enthusiasm seems to initiate a total class activity and to carry the idea along, so the procedure is outlined, and the small sterilized bottles are brought forth from the cupboard and carefully concealed in purses (not without some emotional tension for the few, to be sure — but bolstered with the teacher's comment that this screening test is one of the most valuable and needs to be understood with an adult attitude.) A committee from the classes happily sets up the testing table with plastic cover, test tubes, racks, medicine droppers, water flasks, all borrowed from the chemistry laboratory; paper towels; and the bottle of tablets and the bottle of test solution. The next day most of the specimen bottles are returned and in groups of eight around the table the pupils run the two tests. Nervous hands and watchful eyes betray the dread of finding a positive reaction and the relief following the test seems almost to impel the timid souls to participate in the activity. The test table reduced in size remains in the class room so that any pupil may run the tests at another time if necessary. This particular class experience gets an A rating from the pupils. It should also rate well as an educational method for certain hidden values such as breaking down the emotional barriers and overcoming a false modesty concerned with the words "urine" and "unrinalysis," the experience of collecting and carrying a specimen for testing, and seeing the reason for so doing when the physician makes such a request.

It is through the security of the group in action that the timid ones get up the courage to follow suit so that to date we have had 100% participation. Most of the families are aware of the activity and it is most satisfying to have parents report their interest and approval. Some health teachers prefer to have the urine testing done by the chemistry classes but for the little extra work and bother required to carry this program through (and pupils are so willing to help), I should not want to sacrifice the personal gain to the individual pupil who runs his or her own tests.

Our attack upon the subject of tuberculosis is made through cooperation with our County Tuberculosis and Health Association. To introduce this particular public health problem we borrow from the agency a romance-centered film which provides the interest motivation and very easy identification of the pupils with the film personalities. The public health measures in dealing with tubercular individuals and contacts, the diagnostic tests, treatment and rehabilitation programs are so realistic when they involve the persons who seem so real on the screen. The health educator from the agency arranges to be at one school for a whole day that same week and brings with him some literature, a model of a lung, a viewer and some plates, that prove how much the x-ray discloses. The next day the mobile unit arrives to x-ray the chests of each junior and senior pupil. This planned program, we think, provides a perfect experience for learning about tuberculosis and the community resources concerned with the problem — and also for doing what we know we should do as public-health-minded citizens.

With all the four screening activities finished we come next to the preparation of the classes for the physical examination which is to be the culminating experience for the unit on personal health. From our success in the past seven years we had anticipated that our particular pupils would be interested in this part of the program, granted that the idea is well introduced to them so that they come to understand the value of such a procedure which is planned to take place right there in the adjoining school room and during the school day. With the arrangements made for privacy, a group of four or five classmates will arrive as scheduled, remove their outer clothing and don the "angel capes," and in turn enter the inner room to meet the doctor. Since we have no nurse on duty for these examinations it becomes an obligation for the health teacher to be in close proximity to the examining room, even in it with the few girls for whom a bit more security seems so necessary. Since these examinations are designed pri-

marily as educational experiences rather than specifically for case finding, the pupils are prepared with previous classroom discussions to get the most out of the experience. They must be helped to see that here is opportunity to talk to the doctor.

Two weeks prior to the doctor's coming, the especially prepared health cards for the 11th grade health course, are given to the pupils and by recalling some of the films we have seen to date and utilizing the incidents as background, we point up the importance of the medical history and the pupil fills in this data on his card as well as he can remember. Since he needs help from home to get the correct information he is permitted to take the card home. Now it is the child's chance to explain the activities of the health course and to secure the parents' *request* (not consent) that their child be given the advantage of a physical examination at the school. The request slip and the health card are returned to the school.

Prior to last year, it was possible to have a woman doctor do the physical examinations for the girls in all the high schools. When there was no woman doctor available, the girls themselves pointed out that a male doctor would be quite as satisfactory to them, and they requested that the examinations be scheduled. We did have a very comfortable experience and we feel that another milestone in health education has been achieved from having met the situation in this way.

There is such a wealth of teaching material in the field of health education that with little effort one may stimulate at least a good share of the class on any health topic. Take, for instance, some motivating devices for teaching about the circulatory system. The chemistry department can make very real looking "blood" from Eosin and the ten pint bottles of this liquid in front of a class has an appeal way beyond the imagination. Blood composition related to the laboratory tests done on this vital tissue, questions about transfusions, Rh factor, anemia and all the other ideas that pupils wonder about come thick and fast. A Talquist hemoglobin booklet in the classroom brings from many pupils a desire to be tested but our program has not progressed to the degree which includes this puncture test. Dramatization before the whole school of the activities observed at the American Red Cross Blood Center was a fine project — complete with cots on stage and girls in borrowed Red Cross uniforms escorting a "Volunteer Donor" (one of the class members) through the various procedures. This activity provided an exciting bit of learn-

ing — best of course, for the committee of pupils who undertook the assembly program.

A stethoscope brought to class during the study of the heart was of sufficient interest to stimulate students to come back to the health room in their free time to listen to the lub-dub sounds for themselves. "What is the correct pulse rate for girls our age?" they ask. Taking pulse rates, in groups of three, provides a means of learning about the pulse and pooling their counts on one another show the normal variations. Skill in counting the pulse rate can be taught at the same time in this purposeful activity.

Sometimes an entirely different angle of presentation of a health or safety problem may be the stimulus for applied learning beyond the walls of the classroom. Such a situation resulted last year when our school newspaper entered a national traffic-safety contest. The unit of study on traffic safety in the health course was undertaken at once and the subject was tremendously vitalized through an all-out school program. Posters, exhibits, standard tests to find the winners and a master quiz show kept the learning opportunities alive. A court session conducted in the auditorium for the whole school with one of the municipal judges and his court personnel as guests contributed very much toward making the program effective by "trying the cases" of student traffic offenders and explaining the violation and the law involved. The girls made a dramatic appeal to the boys to drive safely on their dates.

Each year we invite the State Highway Patrolman for a day so that he may show his slides and speak informally about traffic problems to the separate classes. He is a man whose first-hand information about accident causation and effect bears no argument from youth. Likewise, an insurance agent as their guest, makes very plain what the law may exact of the young drivers and their parents when accidents occur.

Utilizing persons in the community, who know their respective areas of information so much better than a teacher could be expected to know them, brings a dynamic impetus to the school health work. We are all interested in teaching our boys and girls to be safe and healthy — it is well that we demonstrate community cooperation in the effort.

Other units of study as previously mentioned and the subunits of mental health, sex education, dating and preparation for family living also need planned vitalization experiences since their effectiveness in the lives of children depends solely upon the impact made by a pluralistic attack on these subjects. The teaching in

this area has to be less direct but certainly very forceful, using shared experiences of class members or related learning from their churches, panel discussions with boys as guest panelists "to cast the male slant" on the subject under consideration, poetry, stories, and socialized test questions through which the pupils are stimulated to think through a problem "on paper."

So-called taboo subjects have come into style in all circles of society and the high school must not fail in its duty to meet "with truth and righteousness" the interests and needs of adolescents who are struggling to shake off traditional restraints with too little preparedness for doing things their way.

Today we are teaching the parents of tomorrw. Through a vitalized health course in the high schools, we hope to close the gap so that the next generation of children shall have better understanding of the ways and means of living healthfully and promoting such public health measures that cope with the problems of their time. It is up to us!

* * * * *

REVIEW

Health for College Students—Cleveland P. Hickman, Head of Zoology Department, Depauw University. Publ. by Prentice-Hall, Inc., Englewood Cliffs, N. J. 1958. Price $6.25.

This is a new and challenging text for college students which stresses the importance of health maintenance and promotion through the building of attitudes and habits. The traditional emphasis on body structure and function, which has long been the basis for most courses in college hygiene has been largely minimized and attention supplemented by directing the individual student toward an understanding and solution of his personal health problems.

The text is adequately illustrated and the subject matter is divided into four main topics; Health Problems and Interests, Beginning Life, Routine Living, and Protecting Your Health. The discussions are student-centered as they deal with the individual in his daily health relations with his family and the community.

Annotated selected references to newer studies follow each of the 36 chapters which are devoted to special health problems within the four areas named above.—M. A. H.

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January, 1958

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MEETING

The 25th Annual Conference of the Michigan School Health Association and Regional Conference, American School Health Association was held in Detroit, Michigan, May 9, 1958, and considered the topic of *School Health in this Atomic Age.*

G. Hoyt Whipple, a biophysicist from the University of Michigan, gave the keynote address which was then discussed by a multi-disciplinary panel headed by Dr. Ernest O. Melby of Michigan State University.

THE ROLE OF PARENTS IN THE COMMUNITY HEALTH PROGRAM

KENNETH E. VESELAK, *Ed.D.*
Queens College, L. I. C. 3, N. Y.

Parents play an important role in the development and maintenance of a healthy community. Their habits, attitudes, beliefs, prejudices, and actions are vital forces in determining the quality of the community health program provided. They should have a thorough understanding of the role they play in maintaining and improving the health of the community.

Parents have essentially three responsibilities in relation to community health. These include the following: (1) they are responsible for the maintenance and improvement of their own personal health; (2) they are responsible for the maintenance and improvement of the health of their children; and (3) they are responsible for the quality of the public health program provided for all the citizens of the community.

In relation to their own health, parents are responsible for providing a healthful and safe home environment; obtaining adequate nutrition, sleep, exercise, and recreation; getting the necessary dental and medical care when needed; and taking precautions so that illness will not occur and disease will not spread.

Parents are also responsible for the health of their children. The responsibility of the parents in providing the opportunity for healthful development begins before the child is born and extends throughout his school life until he becomes mature enough to care for his own health needs. This responsibility has been clearly stated by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association:

> The first and principal responsibility for the child as a human being—a total organism—and therefore the health of that organism must always rest upon the home. Insofar as children are concerned, parents have responsibilities which should not, in the interests of their offspring, be assigned to others. The school must inspire and encourage parental acceptance of all such responsibilities.[1]

During the preschool years the parents should provide an atmosphere in which physical, mental, emotional, and social growth can flourish. Adequate food, shelter, and clothing should be provided so that the child can reach maximum growth and maintain optimum health. Parents should encourage proper health practices

1 Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, **Health Education**, Fourth Edition, Edited by Charles C. Wilson, Washington, D. C., The National Education Association, c 1948, p. 80.

relating to sleep, a well balanced diet, personal cleanliness, suitability and care of clothing, and proper use of leisure time. Provision should be made for regular medical and dental examinations and protective immunization. Sudden illness should be given the immediate attention of a physician. Ideally, when the child enters school he should be in good physical and mental health. All remediable defects should be corrected and the child should be free of bad health habits. The parents should deliver to the school the best possible "raw material" for education in the shape of healthy children.

During the child's school years the parents still provide adequate food, clothing, and shelter for the child as well as a healthful home environment and adequate medical and dental care when needed. Parents must also work in wholehearted cooperation with the school in its attempt to carry on a health education program. In order for parents to cooperate effectively with the school they should be kept informed about such things as: (1) the purposes of the school health program; (2) the responsibilities of the school for the health of the child; (3) policies regarding accidents and sickness occurring during school hours; (4) immunization requirements; (5) the purpose and nature of the medical examination and other health services; (6) the parent's role in the school health program; (7) information about athletic insurance; (8) the functions of school health personnel; and (9) community agencies from which health services can be obtained.[2] Parents can be kept informed about the school health program with the aid of Parent-Teacher Association meetings, child welfare conferences, nurse-parent and teacher-parent conferences, bulletins, pamphlets, and flyers. Only through an adequate program of two-way communication between the parents and the school authorities will a superior program of health promotion and maintenance be provided for the child.

It should be noted that the parents play an exceptionally important role in determining the success of the health service phase of the school health program. It is the responsibility of the parents to get the needed medical and dental treatment for the child based on the finding of the school health officials. In speaking of this responsibility of the parents the Educational Policies Commission has stated that:

2 National Education Association and the American Association of School Administrators. Educational Policies Commission, **Social Services and the Schools**, Washington, D. C., The National Education Association, c1939, p. 76.

Medical diagnoses and necessary treatment are responsibilities of the home and family doctor or the home and public welfare agency in cases of indigency. School authorities fit into the picture at two points: it is their responsibility to acquaint parents with the existence of defects and health handicaps in the child; also it is their task to use every educational device to bring action by those parents on behalf of the child . . . The school's task may be that of educating parents to secure assistance from an appropriate agency.[3]

While school authorities are directly concerned with the health needs of every child, medical care is a medical service and, as such, lies outside the responsibility of the public schools. It is a well established principle that "the school health service should do nothing for the child that can be done effectively by the family, unless it is something primarily for the education of the child or his parents."[4]

In most cases health needs of pupils should be referred to the child's family for treatment. This policy, at once, has the effect of strengthening the family as a unit of society while relieving the school from the tendency to assume non-educational functions . . .[5]

If the child attends an institution of higher education the parents will still have the primary responsibility for his health. It should be noted, however, that at the college level it is quite common for the institution to assume the responsibility for the medical treatment of the student. Many institutions of higher education have completely equipped infirmaries or hospital facilities to treat students who become ill while in attendance. These medical services are financed by an annual or semi-annual fee paid by the students. This fee entitles each student to stipulated services, usually including a certain number of days of hospitalization. The relationships that existed between the parents and the school authorities at the elementary and secondary school levels should also exist at the college level. The parents should cooperate with the college staff in whatever way they can. The college should keep the parents informed about all phases of the health program. Provision should be made for a two-way communication between the college and the home in order that efforts can be coordinated in meeting the health needs of the student.

The parents' efforts to meet the child's health needs while in school and college are reinforced and supplemented by the work of the educational institutions, physicians, dentists, nurses, official health agencies, and voluntary health agencies. Once the child begins to work in his chosen profession, he is usually mature enough to provide for his own health needs and eventually, the

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3 **Loc. cit.**

4 National Education Association and the American Association of School Administrators, Educational Policies Commission, **Social Services and the Schools**, Washington, D. C., The National Education Association, c1939, p. 76.

5 **Ibid.**, p. 77.

health needs of his family. At this time the parents' responsibility for the health of the child terminates.

A final responsibility of the parents in the community health program is that of maintaining and improving the quality of the public health program provided for the citizens of the community. They should take an active part in determining the health needs of the community by serving on committees and participating actively in health projects conducted by community health agencies. Once these needs are detected, the parents should see to it that they are adequately met.

Parents also play an important role in supporting legislation that will help to elevate the quality of the community health program, and volunteering their services to community health agencies. They should have a concern for community regulations regarding safety, public health, and recreation, so that adequate conditions of housing, inspection and control of food, milk, and water supplies, contagious disease control, traffic regulations, and other aspects of the community's responsibility for the health and safety of its citizens will be provided. Parents should also abide by all public health laws and regulations and cooperate with health agencies in maintaining the health of the community.

In order that parents may effectively carry out their role in the community health program, they should be given the opportunity to participate actively in all types of coordinating councils including community health councils and school health councils. They should be given the opportunity to take an active part in determining the health standards of the community in which they are going to live.

* * * * *

MEETING

ASHA Tuberculosis Committee—The meeting of the Tuberculosis Committee held annually in conjunction with the National Tuberculosis Association occurred May 19 in Philadelphia.

J. Arthur Myers, M.D., Chairman of the Committee, had arranged a program of five excellent papers by distinguished leaders in Tuberculosis Control Through the Schools. Ruth Weaver, M.D., ASHA President, gave the address of welcome and aided Dr. Myers in conducting the meeting.

SPEAKING OF SCHOOL ACCIDENTS

ROBERT D. RUSSELL, *Ed.D.*
Assistant Professor of Health Education, Stanford University
Stanford, California

The statement, "Accidents have become one of our major concerns in school health," is neither new nor startling. From practical experiences in the schools we would probably agree with Diehl[1] when he says, "For young people of school age, most accidents occur at school or on the way to and from school. Usually school accidents are not fatal, but many result in serious injury." Teachers are asked to accept responsibility for preventing or reducing the accidents in their schools, yet the evidence on when, where, and how accidents happen—and to whom—is very sketchy, if existent at all. Another investigator has come to this same conclusion, particularly as such information is related to cause of accidents, and adds, "At present most of the information available refers to fatal accidents."[2]

This, then, is a careful analysis of the accident picture of one rather large school for one school year. The study is important only as it sets a factual picture from which better supervision practices may be spawned, AND as it encourages other schools and districts to carry on similar evaluations.

This study is concerned with the analysis of the accidents reported to the school nurse at Punahou School, Honolulu, Hawaii, during the academic year 1956-1957. (The author was the head of the school health department and chairman of the school health committee during this year.) In cases where parallel data are available from other studies, comparisons with the Punahou experience will be offered.

Punahou School is an independent, non-denominational school, the largest of its kind under jurisdiction of the United States. Though its student population comes mainly from the city of Honolulu, all areas of Oahu are represented, as are all the Neighbor Islands. As a private school it draws from no one district; students come from virtually all areas of the city. The school population, as a whole, comes from middle and upper-middle class homes, with a small minority representing the upper class and the lower class,

1 Harold S. Diehl and Anita D. Laton, **Health and Safety for You** (New York, McGraw-Hill Book Co., Inc., 1954) 33.

2 Ross A. McFarland, "Epidemiologic Principles Applicable to the Study and Prevention of Child Accidents," **American Journal of Public Health**, 45:1303, October, 1955.

sociologically speaking. Thus, the school would be comparable to many public schools found in the suburbs of prosperous cities — schools enrolling a fairly homogeneous population.

The advantage of studying this population is seen in the fact that grades one through twelve are located on the same campus, use the same infirmary, and have their accidents reported in the same manner by the same nursing staff.

The total student population under study numbered 2813. Of these, 552 (20 per cent) were of Oriental ancestry, 292 (10 per cent) were classed as Hawaiian or part-Hawaiian, and the remaining 70 per cent were white-Caucasian.

LIMITATIONS OF THE STUDY.

1. The study is limited to one academic year, 1956-57.

2. The study is limited to a consideration of only those accidents reported to the school nurse and recorded on the school accident form. It does not include accidents and injuries sustained in competitive high school athletics; these are reported separately to the athletic trainer.

GENERAL INTENT OF THE STUDY.

The general intent of the study was to discover when accidents happened, how they occurred, what kinds of students were involved, and what accidents were most common.

THE FINDINGS.

1. There were a total of 155 accidents reported during the period from September 5, 1956 to June 5, 1957. 139 students had one reportable accident, six students had two accidents, and one student was involved in four separate mishaps. Thus, 5.2 per cent of the total student body were involved in reported accidents. Stated another way, there were 5.5 accidents/100 students.

2. MONTH. Accidents were most frequent during the months of February, March, and April; March had the highest number with 26, while March and April showed the highest averages—1.24 and 1.25 per day. The mean accident total was 17.1 per month. The total picture by months is shown below.

MONTH	No. of Sch. Days	No. of Accid's	Aver. Per Day
September	19	16	0.84
October	23	19	0.83
November	19	12	0.63
December	15	7	0.47
January	19	15	0.79
February	19	21	1.11
March	21	26	1.24
April	16	20	1.25
May	22	18	0.82

3. TIME OF DAY. The time period in which accidents occurred most frequently was that between the hours of 11 A.M. and 12 noon. 38 accidents (25 per cent) occurred during this space of time. The next two most accident-prone time spans were 10 A.M. to 11 A.M. (24 accidents — 15 per cent) and 12 noon to 1 P.M. (20 accidents — 13 per cent). The table for the entire school appears below.

TIME SPAN	No. of Accid's	Per Cent of Total
7- 9 A.M.	15	9
9-10 A.M.	17	11
10-11 A.M.	24	15
11-12 A.M.	38	25
12- 1 P.M.	20	13
1- 2 P.M.	18	12
2- 3 P.M.	14	9
After 3 P.M.	9	6

4. SEX. 99 of the 155 accidents (64 per cent) happened to boys, whereas 56 (36 per cent) involved girls. Thus, a boy was almost twice as likely to be in an accident as a girl.

5. AGE. Age thirteen was the year group recording the largest number of accidents (29 or 19 per cent); age thirteen was followed by age eleven (22 or 14 per cent) and age twelve (21 or 13.5 per cent). Thus, nearly one-half of the accidents occurring in the whole school for the entire year involved students ages eleven to thirteen. The table below shows the complete distribution.

Age	No. of Accid's	Per Cent of Total
6	4	3
7	7	5
8	5	3
9	14	9
10	13	8
11	22	14
12	21	14
13	29	19
14	14	9
15	10	6
16	8	5
17	6	4
18	2	1

6. GRADE. As would be expected, the grade pattern followed the age picture, with grade eight recording 29 accidents (19 per cent) — the same figure as for age thirteen. Next highest was grade seven with 24 mishaps or 15 per cent. The total breakdown by grades is shown below.

GRADE	No. of Accid's	Per Cent of Total
1	4	3
2	7	5
3	10	6

4	10	6
5	20	13
6	16	10
7	24	15
8	29	19
9	11	7
10	12	8
11	9	6
12	3	2

7. RACE. 116 of the accidents (75 per cent) involved Caucasian children, which is slightly higher than the ratio in the school population (70 per cent). However, only 18 accidents (12 per cent) occurred involving Oriental children (Japanese, Chinese, and Korean), a percentage figure considerably lower than their ratio in the population (20 per cent). The other 13 per cent of the accidents involved students of Hawaiian, part-Hawaiian, and other mixed racial extraction. Thus, Caucasians and Hawaiians — part-Hawaiian students had proportionately more accidents, while Oriental children had proportionately less. Proportional differences were not great, however.

8. WHERE OR HOW. 38 of the accidents (25 per cent) occurred on the playground, where students were playing with little or no organization; 23 (15 per cent) of the accidents occurred within a classroom building; 39 (25 per cent) involved school facilities of one type or another. The remainder of the accidents happened around the school campus (10 per cent) or in physical education classes (25 per cent). 21 (or 14 per cent) of the mishaps were a direct result of carelessness or general "horsing around."

9. TYPE OF INJURY. The most frequent type of injury was found to be a sprain or a strain (usually involving a joint) — 58 or 37 per cent. Cuts were number two in frequency — 45 or 29 per cent. The only other category of significance was that of bruises, which included 23 or 15 per cent.

TYPE OF INJURY	Number	Percentage*
Sprain or Strain	58	37
Cut	45	29
Bruise	23	15
Headache	9	6
Puncture Wound	8	5
Eye Injury	6	4
Abrasion	6	4
Fracture	4	3
Splinter	2	1
Burn	2	1
Broken Tooth	1	1
Toenail Loss	1	1

*(Since ten of the accidents produced multiple-type injuries, the percentages in this column add up to more than 100 per cent.)

10. BODY PART INJURED. The most frequent type of injury involved one or more fingers (28 or 18 per cent); the next most-injured body region was the foot and/or toes (27 or 17 per cent). The extremities (hand, fingers, ankle, foot, and toes) were involved in a total of 89 accidents (or 57 per cent). The complete picture is given below.

BODY REGION	Number*	Percentage
Fingers	28	18
Toes-Foot	27	17
Ankle	21	14
Head	18	12
Arm-Wrist	15	10
Hand	13	8
Chest-Back-Shoulder	12	8
Face	11	7
Leg	8	5
Eye	6	4

*(Four accidents involved a multiple location.)

11. SOME INTERESTING NOTES.

a. The accidents ran the gamut from a test tube explosion involving an eleventh grade student to a fall off of the teeter totter by a second grader.

b. The accident that would be least likely to happen on the mainland was that of a fourth grade boy who was hit in the eye with a coconut.

c. Only three trampoline accidents were reported during the entire year; two of these occurred on October 24 and the third on October 25.

d. Ten accidents happened on stairs or steps.

e. Eight accidents took place in the school shops; four occurred in the chemistry labs.

f. The most dangerous physical education activity for boys in grades 6-8 (on the basis of accidents reported) was track, accounting for eight injuries, five of which resulted from high jumping.

CONCLUSIONS AND OBSERVATIONS.

1. The figure of 5.5 accidents/100 students seems reasonably normal for a school year in this type of school. (As indicated in the delimitation, this study does not include most of those injured while participating in the high school after-school sports program.) This figure compares favorably with the rate reported by Haar and Martin[3] in their study of accidents in the secondary schools of Oregon in 1952, where their compilation of the accident rate showed slightly more than 6 accidents/100 students.

3 Frank B. Haar and Don B. Martin, "Student Injuries in Secondary Schools in Oregon," Research Quarterly, 24:277, October, 1953.

2. There was no noteworthy change in the type of accidents that occurred in the spring as contrasted with those in the fall (except for the track mishaps); therefore, it appears that the early spring months see a spurt of new, reckless energy, which results in a higher accident rate. The Oregon study previously cited generally presents the same picture (more accidents during the second semester), though February was high in this instance, followed by March and April.[4] Griffin[5] says, in reporting a limited survey of the accidents in Chicago schools, that "the warmer weather of March, April, May and June will bring pupils into more outside activities both at school and in their out of school life" and suggests that planning for accident prevention should be intensified in this period. This, however, would be true to only a limited extent in Hawaii, where seasonal changes are slight.

3. There were no injuries reported that would appear to be permanently serious. Some of the cuts may result in scars, and the one broken tooth would have to be capped, but all fractures were uncomplicated, and none of the eye injuries resulted in permanent loss of vision. This, of course, is a very encouraging part of the whole study picture.

4. The time period for most accidents (11 A.M. to 12 noon) is not surprising, in that this time is the lunch period for grades 1-8; accidents would be more likely to occur when the student was in a hurry — to lunch or to play afterward. Also there might be a greater tendency to report to the nurse during the lunch hour than at some other time — when the accident was not major in character.

5. The age and grade range for greatest accident expectation was not surprising, in that these pre-adolescent and early adolescent youngsters combine energy and recklessness with a loss of coordination due to sudden, increased growth. Though teachers, playground supervisors, and P. E. instructors can be aware of the increase at this age and try to encourage prevention, the factors just enumerated would seem to preclude much decrease in accident rate.

6. The only surprising thing about the Where and How of the accident picture was that only 14 per cent were the direct result of careless play or "horsing around." It is probably that more of the other accidents had this element as a contributing

4 Ibid.

5 James J. Griffin, "Where School Accidents Occurred First Semester School Year 1955-56," **The Journal of School Health**, 26:188, June, 1956.

factor, but the victim did not include such testimony in his description of the occurrence.

7. The types of accidents most frequently seen (sprains, strains, and cuts) and the body parts most involved (extremities) would again reflect reckless energy and lack of coordination and/or experience in new activities. The rather high percentage of injuries to feet and toes probably stems from the fact that youngsters below grade six do not wear shoes to school and that most of the students in grades seven and above attend P. E. classes in bare feet.

8. In further comparison with the study of accidents in the Oregon secondary schools (noting that nearly half of the Punahou sample were elementary children and therefore not directly comparable), there is disagreement on the most dangerous hour—Punahou's 11 A.M.-12 noon against Oregon's 3 P.M.-4 P.M. (This study like the one here reported, did not include injuries incurred in interscholastic athletics.) There is agreement on the most frequent type of injury (sprain or strain), and slight disagreement on the most frequently injured anatomical region (Oregon listing ankles, then fingers, while Punahou was "favoring" fingers, toes, and then ankles).[6]

9. On the basis of accidents reported it might be well to assess whether high jumping was an activity requiring more coordination (at the minimum height of the varsity standards) than sixth, seventh, and eighth grade boys generally possess.

10. This study of accidents for a year's time is admittedly a microcosmic look and is not necessarily indicative of what the picture would be in this school (or in similar schools) each year. Yet it is a start — an attempt to set some yardstick for continuing evaluation.

SUMMARY: In an analysis of the accidents reported to the school nurse by students in grades 1-12 at Punahou School during the school year 1956-57 it was found that the spring months (February, March, and April) were the most accident-full. The time between 11 A.M. and 12 noon saw the most accidents occur; accidents happened most frequently to seventh and eighth graders or students between the ages of eleven and thirteen. Males outnumbered females in the accident picture almost two to one. Students of Oriental ancestry had fewer accidents than their numbers in the student body would predict. About half of the accidents occurred on the school playground or in P. E. classes. Sprains and strains

6 Haar, **op. cit.**, p. 277-280

were the most frequent type of injury, while fingers, toes, and feet were the most injured body regions. This study was designed to provide a yardstick for continuing evaluation of this phase of the school health program.

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REVIEWS

The Instructor Kit on the Human Body.—John H. Shaw, Prof. of Health and P.E., Syracuse Univ., with Glenn Sprague and James Palmer. Publ. 1958 by F. A. Owen Publ. Co. Price $15.00 F.O.B. Dansville, N. Y.

This very usable kit consists of: a) ten colored and well labeled wall charts, each showing a primary body part or system large enough to be easily visible across the room, b) thirty illustrated booklets for individual pupil use, written in clear, simple style, describing each of the ten topics covered by the charts, and c) a teacher's guide containing adequate background material for the presentation of each topic. The kit is portable and provides an excellent teaching aid to supplement a health curriculum geared to the upper elementary grades.—M. A. H.

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School Health Program by Jessie Helen Haag, Ed.D. 533 pages, $6.50.

This publication is well organized and written from the teacher's point of view and is a good introduction to the School Health Program.

It is divided into eight parts, School Health Services; Safe and Healthful School Environment; School Nutrition; Community Resources; Health of the School Personnel; School Day and Its Relationship to the Pupil's Total Health; Health and Safety Instruction; and Organization and Administration of the School Health Program. The total health program is presented in terms of these eight related parts brought together by the teamwork of school and community personnel.

The author has had wide experience in health education work. This with her years of teaching at the University of Texas makes the text quite practical and teachable.—A. O. DeWeese, M.D.

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